

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 20 1957

40204

STATE FILE NUMBER

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

5131

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY (If outside, give location) OR TOWN Hickman Mills	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Joseph Hospital		d. STREET ADDRESS 9911 E. 80th St.	
3. NAME OF DECEASED (Type or print) First Infant Middle Bicknell Last Bicknell		4. DATE OF DEATH Month Nov , Day 2 , Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inf.		11. BIRTHPLACE (City and state or country) Kansas City, Mo.	
10b. KIND OF BUSINESS OR INDUSTRY None		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Bicknell		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Bicknell		Address 9911 E. 80th st.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure attendant of lungs pre existing Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) pre existing DUE TO (c) pre existing PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 minutes 1 hour 16:25
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION Hickman Mills		COUNTY Mo. STATE Mo.	
21. I attended the deceased from 4-2-57 to 11-2-57 and last saw her alive on 11-2-57 Death occurred at 5:45 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John T. Skinner		22b. ADDRESS 1102 Grand St. CM 17-357	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 4, 1957	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Hickman Mills, Mo.	
24. FUNERAL DIRECTOR Mellody McGilley Eylar		25. DATE RECD. BY LOCAL REG. 11-3-57	
ADDRESS Kan City, Mo.		26. REGISTRAR'S SIGNATURE Reva Minshall	

(Licensed Embalmer's Statement on Reverse Side)

John T. Skinner
MEDICAL CERTIFICATION
Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Prof Bicknell

Dr J. T. Skinner
wa 17717

Signed



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John C. Alderson

Licensed Embalmer No. 5025

P. O. Address Indy, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.